SWEDISH
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PLEASE LIST ANY ALLERGIES OR MEDICATION INTOLERANCES YOU MAY HAVE (Please describe what happens)
(Include medicines, foods, adhesives, etc.)

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

YOUR MOBILITY

I walk independently	☐ Yes	☐ No
I need help walking	☐ Yes	☐ No
I use mobility aids	☐ Yes	☐ No
I depend on a wheelchair	☐ Yes	☐ No

ABOUT YOUR REGULAR DOCTOR

Have you ever discussed your visit to our clinic with your regular doctor?	☐ Yes	☐ No
Can we send them reports of your progress?	☐ Yes	☐ No
Can we send other consultants reports of your progress?	☐ Yes	☐ No
Have you ever been a patient of this hospital before?	☐ Yes	☐ No

ALCOHOL, TOBACCO AND CAFFEINE CONSUMPTION

Which have you used in the past? ☐ Alcohol ☐ Tobacco ☐ Caffeine

Which do you currently use? ☐ Alcohol ☐ Tobacco ☐ Caffeine

Alcohol type:_____ **used x**_____ **per day for** _____ **years**

Tobacco Type:_____ **used x**_____ **per day for** _____ **years**

Caffeine Type:_____ **used x**_____ **per day for** _____**years**

Are you depressed? ☐ **Yes** ☐ **No**

Have you thought about harming yourself? ☐ **Yes** ☐ **No**

LIST ALL SURGERIES, TYPE AND YEAR:

LIST ALL HEALTH PROBLEMS YOU HAVE HAD

Diabetes Mellitus	☐ Yes	☐ No
I Monitor Glucose Regularly	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Hepatitis/ Liver Disease	☐ Yes	☐ No

Other:

ACTIVITES OF DAILY LIVING

Check one: **I= Independent (can do by yourself)**
A= Assistance (can do with help)
D= Dependent (need someone to do for you)

Dressing	☐ I	☐ A	☐ D
Cleaning House	☐ I	☐ A	☐ D
Eating	☐ I	☐ A	☐ D
Cooking	☐ I	☐ A	☐ D
Bathing	☐ I	☐ A	☐ D
Grooming	☐ I	☐ A	☐ D
Toilet	☐ I	☐ A	☐ D
I can perform a normal day of activity	☐ YES	☐ NO	

Other:

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WOUND INFORMATION

Location_____ **Date First Noted**_____

Location_____ **Date First Noted**_____

Location_____ **Date First Noted**_____

Location_____ **Date First Noted**_____

What caused the wound/s to develop?_____

_____

Have you received treatment before? ☐ **Yes** ☐ **No** **Was the treatment effective?** ☐ **Yes** ☐ **No**

REPORT PREVIOUS WOUND TREATMENTS

☐ **Whirlpool**	☐ **Hyperbaric Oxygen**	☐ **Transparent Dressing**	☐ **Unna Boot**	☐ **Hydrogen Peroxide**
☐ **Total Contact Casting**	☐ **Soaks**	☐ **Hydrocolloid Dressing**	☐ **Plain Gauze Dressing**	☐ **Other:**
		☐ **Topical Gel / Ointment**	☐ **Betadine**	

REPORT HOME/ LIVING ARRANGEMENTS

Lives Alone ☐ **Yes** ☐ **No** **Concerns about needs after treatment at the CWHH is completed** ☐ **Yes** ☐ **No**

Do you feel safe at home? ☐ **Yes** ☐ **No**

Other_____

REPORT PAIN

Scale: ☐ **None 1 2 3 4 5 6 7 8 9 10** ☐ **Frequent** ☐ **Occasionally** **Times**_____

☐ With dressing change ☐ During treatment ☐ After treatment ☐ Awakens me at night

Duration of pain: ☐ Several hours ☐ Most of the day ☐ Day and Night ☐ All night

Character of pain: ☐ Stabbing ☐ Burning ☐ Aching ☐ Cramping ☐ Spastic ☐ Dull ☐ Sharp

Location of pain: ☐ Wound area ☐ Below wound ☐ Above wound ☐ Entire limb ☐ Bottom foot ☐ Calf

☐ Buttocks ☐ Other_____

What helps to relieve the pain?:

What does not help?:

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REPORT PROBLEMS WITH BODY SYSTEMS ***(check if applicable, mark with a "0" if section is answered with all "no's")***

GENERAL
- ☐ Weight loss 10 lbs or more
- ☐ Weight gain 15 lbs or more
- ☐ Too Cool
- ☐ Too Warm
- ☐ **Other:**_____

MUSCLES/ BONES/ JOINTS
- ☐ Leg Pain- At Rest
- ☐ Leg Pain-While Walking
- ☐ Back Pain
- ☐ Joint Aching / Pain
- ☐ Swelling of Joints
- ☐ Difficulty w/ Joint Motions
- ☐ **Other:**_____

NEUROLOGICAL
- ☐ Change in Memory
- ☐ Trouble with Balance
- ☐ Change in Sensation
- ☐ **Other:**_____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Irregular
- ☐ High Blood Pressure
- ☐ Use Oxygen at Home
- ☐ Pacemaker
- ☐ Swelling in Ankles
- ☐ **Other:**_____

HEAD, EYES, EARS, ECT.
- ☐ Frequent Headaches
- ☐ Blurred / Double Vision
- ☐ Dizziness
- ☐ Change in Hearing
- ☐ Ringing in Ears
- ☐ Sore Throat
- ☐ Trouble Swallowing
- ☐ **Other:**_____

RESPIRATORY
- ☐ Frequent Colds
- ☐ Difficulty Breathing
- ☐ Cough w/ Dark Phlegm
- ☐ Asthma / Hay Fever
- ☐ Emphysema
- ☐ **Other**_____

BLADDER, KIDNEY
- ☐ Frequent Urination
- ☐ Burning on Urination
- ☐ Blood in Urine
- ☐ Difficulty with Urination
- ☐ **Other:**_____

DIGESTIVE
- ☐ Heartburn
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black Stools
- ☐ Blood with Stools
- ☐ Nausea
- ☐ Special Diet
- ☐ Clear Liquids Only
- ☐ Inability to Chew
- ☐ **Other:**_____

GYNECOLOGICAL
- ☐ Last Menstrual Period
- ☐ Irregular Periods
- ☐ **Other:**_____

SKIN
- ☐ Rash
- ☐ New Growths
- ☐ Color Change-Mole / Wart
- ☐ **Other:**_____

Do you have an Advance Directive? ☐ **Yes** ☐ **No**

Patient / Patient Representative Signature_____**Date**_____